Title 210 - NEBRASKA DEPARTMENT OF INSURANCE

Chapter 48 - REGULATION TO IMPLEMENT TRANSITIONAL REQUIREMENTS FOR THE COVERSION OF MEDICARE SUPPLEMENT INSURANCE BENEFITS AND PREMIUMS TO CONFORM TO MEDICARE PROGRAM REVISIONS

001. Purpose. The purpose of this regulation is to assure the orderly implementation and conversion of Medicare supplement insurance benefits and premiums due to changes in the Federal Medicare Program; to provide for the reasonable standardization of the coverage, terms and benefits of Medicare supplement policies or subscriber contracts; to facilitate public understanding of such policies or subscriber contracts; to eliminate provisions contained in such policies or subscriber contracts which may be misleading or confusing in connection with the purchase of such policies or subscriber contracts; to eliminate policy or contract provisions which may duplicate Medicare benefits; to provide full disclosure of policy or subscriber contract benefits and benefit changes; and to provide for refunds of premiums associated with benefits duplicating Medicare program benefits.

002. Authority. This Rule is issued pursuant to the authority vested in the Director of Insurance under Neb.Rev.Stat. ' 44-101.01, the Unfair Insurance Trade Practices Act, ' 44-1521 et. seq., and the Unfair Insurance Claims Settlement Practices Act, ' 44-3601 et. seq.

003. Applicability and scope. This regulation shall take precedence over other rules and requirements relating to Medicare supplement policies or contracts only to the extent necessary to assure that benefits are not duplicated, that applicants receive adequate notice and disclosure of changes in Medicare supplement policies and subscriber contracts, that appropriate premium adjustments are made in a timely manner, and that premiums are reasonable in relation to benefits.

003.01 Except as otherwise provided, this regulation shall apply to:

003.01A All Medicare supplement policies and contracts delivered, or issued for delivery, or which are otherwise subject to the jurisdiction of this state on or after the effective date hereof, and

003.01B All certificates issued under group Medicare supplement policies as provided in subsection 003.01A.

004. Definitions.

004.01 For purposes of this regulation:

004.01A "Applicant" means:

004.01A(1) In the case of an individual Medicare supplement policy or subscriber contract, the person who seeks to contract for insurance benefits, and

004.01A(2) In the case of a group Medicare supplement policy or subscriber contract, the proposed certificateholder.

004.01B "Certificate" means any certificate issued under a group Medicare supplement policy or subscriber contract.

004.01C "Medicare Supplement Policy" means a group or individual policy of accident and sickness insurance or a subscriber contract of hospital and medical service association or health maintenance organization which is advertised, marketed or designed primarily to provide health care benefits as a supplement to reimbursements under Medicare for the hospital, medical or surgical expenses of persons eligible for Medicare by reason of age.

005. Benefit conversion requirements.

005.01A Effective January 1, 1989, no Medicare supplement insurance policy, subscriber contract or certificate in force in this state shall contain benefits which duplicate benefits provided by Medicare.

005.01B General Requirements

005.01B(1) No later than thirty (30) days prior to the annual effective date of Medicare benefit changes mandated by the Medicare Catastrophic Coverage Act of 1988, every insurer, health care service plan, hospital and medical service association or health maintenance organization providing Medicare supplement insurance or benefits to a resident of this state shall notify its policyholders, subscribers and certificateholders of modifications it has made to Medicare supplement insurance policies or subscriber contracts. Such notice shall be in a format prescribed by the Director.

005.01B1(a) Such notice shall include a description of revisions to the Medicare program and a description of each modification made to the coverage provided under the Medicare supplement insurance policy or subscriber contract.

005.01B1(b) The notice shall inform each covered person as to when any premium adjustment due to changes in Medicare benefits will be made.

005.01B1(c) The notice of benefit modifications and any premium adjustments shall be in outline form and in clear and simple terms so as to facilitate comprehension. Such notice shall not contain or be accompanied by any solicitation.

005.01B(2) No modifications to an existing Medicare supplement policy or subscriber contract shall be made at the time of or in connection with the notice requirements of this regulation except to the extent necessary to eliminate duplication of Medicare benefits and any modifications necessary under the policy or subscriber contract to provide indexed benefit adjustment.

005.01B(3) As soon as practicable, but no later than forty-five (45) days after the effective date of the Medicare benefit changes, every insurer, health care service plan, hospital and medical service association or health maintenance organization providing Medicare supplement insurance in this state shall file with the Department, in accordance with the applicable filing procedures of this state:

005.01B(3)(a) Appropriate premium adjustments necessary to produce loss ratios as originally anticipated for the applicable policies or subscriber contracts. Such supporting documents as necessary to justify the adjustment shall accompany the filing.

005.01B(3)(b) Any appropriate riders, endorsements or policy forms needed to accomplish the Medicare supplement insurance modifications necessary to eliminate benefit duplications with Medicare. Any such riders, endorsements or policy forms shall provide a clear description of the Medicare supplement benefits provided by the policy or subscriber contract.

005.01B(4) Upon satisfying the filing and approval requirements of this state, every insurer, health care service plan, hospital and medical service association or health maintenance organization providing Medicare supplement insurance in this state shall provide each covered person with any rider, endorsement or policy form necessary to eliminate any benefit duplications under the policy or subscriber contract with benefits provided by Medicare.

005.01B(5) No insurer, health care service plan, hospital and medical service association or health maintenance organization shall require any person covered under a Medicare supplement policy or subscriber contract which was in force prior to January 1, 1989 to purchase additional coverage under such policy or contract unless such additional coverage was provided for in the policy or contract.

005.01B(6) Every insurer, health care service plan, hospital and medical service association or health maintenance organization providing Medicare supplement insurance or benefits to a resident of this state shall make such premium adjustments as are necessary to produce an expected loss ratio under such policy or subscriber contract as will conform with minimum loss ratio standards for Medicare supplement policies and which is expected to result in a loss ratio at least as great as that originally anticipated by the insurer, health care service plan, hospital and medical service association or health maintenance organization for such Medicare supplement insurance policies or subscriber contracts. No premium adjustment which would modify the loss ratio experience under

the policy, other than the adjustments described herein, should be made with respect to a policy at any time other than upon its renewal date. Premium adjustments shall be in the form of refunds or premium credits and shall be made no later than upon renewal if a credit is given, or within sixty (60) days of the renewal date if a refund is provided to the premium payer.

006. Requirements for new policies and certificates.

006.01A Effective January 1, 1989, no Medicare supplement insurance policy, subscriber contract, or certificate shall be issued or issued for delivery in this state which provides benefits which duplicate benefits provided by Medicare. No such policy, subscriber contract or certificate shall provide less benefits than those required under existing Medicare Supplement Insurance Minimum Standards Act or Regulations except where duplication of Medicare benefits would result.

006.01B General Requirements

006.01B(1) Within ninety (90) days of the effective date of this regulation, every insurer, health care service plan, hospital and medical service association or health maintenance organization required to file its policies or subscriber contracts with this state shall file new Medicare supplement insurance policies or subscriber contracts which eliminate any duplication of Medicare supplement benefits with benefits provided by Medicare and which provides a clear description of the policy or contract benefit.

006.01B(2) The filing required under subsection 006.01B(1) shall provide for loss ratios which are in compliance with all minimum standards.

006.01B(3) Every applicant for a Medicare supplement insurance policy, subscriber contract or certificate shall be provided with an outline of coverage which simplifies and accurately describes benefits provided by Medicare and policy or contract benefits along with benefit limitations.

007. Filing requirements for advertising.

007.01 Every insurer, health care service plan, hospital and medical service association or health maintenance organization providing Medicare supplement insurance or benefits in this state shall provide a copy of any advertisement intended for use in this state whether through written, radio or television medium to the Director of Insurance of this State for review by the Director. Such advertisement shall comply with all applicable laws of this state.

008. Buyer's guide.

008.01 No insurer, health care service plan, hospital and medical service association or

health maintenance organization shall make use of or otherwise disseminate any Buyer's Guide or informational brochure which does not accurately outline current Medicare benefits and which is not in a format prescribed by the Director.

009. Severability. If any provision of this regulation or the application thereof to any person or circumstances is for any reason held to be invalid, the remainder of the regulation and the application of such provision to other persons or circumstances shall not be affected thereby.

010. Operative date. The operative date of this Rule is November 30, 1988.